A SELECTION OF TEN CURRENT READINGS ON TOPICS RELATED TO WOMEN'S HEALTH AVAILABLE AS FULL-TEXT (SOME FREE, SOME REQUIRING PAYMENT)

Selection of readings made by A/Prof Goh Lee Gan

The topics related to women's health are menopause, HRT use, cervical screening, uterine fibroid, ovarian cancer, and breast conditions

---

MENOPAUSE

Reading 1

Richardson MK. What's the deal with menopause management? Why the Women's Health Initiative raises more questions than it answers. Postgrad Med. 2005 Aug;118(2):21-6.

URL: http://www.postgradmed.com/issues/2005/08_05/comm_richardson.htm (free full text)

Procter & Gamble Pharmaceuticals, Inc., USA. marcie_richardson@vmed.org

SUMMARY
Since WHI was stopped, doctors and patients have struggled with finding a safe, comfortable, and rational approach to menopause management. In its 2004 position statement, the North American Menopause Society stated that "treatment of moderate to severe menopause symptoms (ie, vasomotor symptoms, sleep disruption from vasomotor symptoms) remains the primary indication for systemic estrogen therapy and estrogen-progesterone therapy." It suggested that using the lowest dose of estrogen that gives symptomatic relief is preferred. An initial dose the equivalent of 0.3 mg of conjugated equine estrogens daily, or half the dose used in WHI, often provides adequate relief of at least hot flashes. The doses 0.625 mg of conjugated equine estrogens, 1.0 mg of estradiol (Estrace, Gynediol), and 0.05 mg of transdermal estradiol per 24 hours are equivalent. Estrogen or estrogen and progestogen therapy deserves a risk-benefit discussion with our patients who have symptoms that might improve with hormone therapy. Only a trial of estrogen can determine the individual patient's response. Although it is necessary to wait several weeks after starting estrogen therapy to receive the full effect, some women feel so much better taking estrogen that the small risk of this therapy is worthwhile until more data or other therapeutic alternatives are available.

HRT USE

Reading 2

Ockene JK, Barad DH, Cochrane BB, Larson JC, Gass M, Wassertheil-Smoller S, Manson JE, Barnabei VM, Lane DS, Brzyski RG, Rosal MC, Wylie-Rosett J, Hays J. Symptom experience after discontinuing use of estrogen plus progestin. JAMA. 2005 Jul 13;294(2):183-93.

URL: http://jama.ama-assn.org.libproxy1.nus.edu.sg/cgi/content/full/294/2/183 (free full text)

Division of Preventive and Behavioral Medicine, University of Massachusetts Medical School, Worcester 01655, USA. Judith.Ockene@umassmed.edu

ABSTRACT
CONTEXT: Little is known about women's experiences after stopping menopausal hormone therapy.
OBJECTIVE: To describe women's symptoms and management strategies after stopping the intervention in a large estrogen plus progestin trial.
DESIGN, SETTING, AND PARTICIPANTS: Cross-sectional survey of 8405 women (89.9%; N = 9351) at 40 clinical centers who were still taking study pills (conjugated equine estrogens plus medroxyprogesterone [CEE +

MPA] or placebo) when the estrogen plus progestin intervention (Women's Health Initiative) was stopped. Surveys were mailed 8 to 12 months after the stop date. Logistic regression was used to model vasomotor symptoms and pain or stiffness symptoms as functions of former treatment and baseline symptoms, adjusted for appropriate covariates.
MAIN OUTCOME MEASURES: Symptoms (vasomotor or pain and stiffness) and management strategies.
RESULTS: Respondents' mean (SD) age at trial stop date was 69.1 (6.7) years. They averaged 5.7 years of taking study pills. Moderate or severe vasomotor symptoms after discontinuing study pill use were reported by 21.2% of former CEE + MPA and 4.8% of placebo group respondents overall and by 55.5% and 21.3%, respectively, with these symptoms at baseline (randomization). Compared with respondents in the former placebo group, moderate or severe vasomotor symptoms (adjusted odds ratio [AOR] 5.82; 95% confidence interval [CI], 4.92-6.89) and pain or stiffness symptoms (AOR, 2.16; 95% CI, 1.95-2.40) were more likely in respondents in the former CEE + MPA group. Both vasomotor symptoms (AOR, 5.36; 95% CI, 4.51-6.38) and pain or stiffness symptoms (AOR, 3.21; 95% CI, 2.90-3.56) also were more likely in women with these symptoms at baseline. Women reported a wide range of strategies to manage symptoms.
CONCLUSIONS: More than half of the women with vasomotor symptoms at randomization to active CEE + MPA also reported these symptoms after discontinuing use of the study pills. However, these participants did not include women who were unwilling to be randomized or who had stopped taking the study pills earlier. These findings should be considered when advising women to treat menopausal symptoms with hormone therapy for as short duration as possible. Investigation of alternative strategies to manage menopausal symptoms is warranted.

Reading 3

Bath PM, Gray LJ. Association between hormone replacement therapy and subsequent stroke: a meta-analysis. BMJ. 2005 Feb 12;330(7487):342. Epub 2005 Jan 7.

URL: http://bmj.bmjjournals.com.libproxy1.nus.edu.sg/cgi/content/full/330/7487/342

Division of Stroke Medicine, Institute of Neuroscience, Queen's Medical Centre, University of Nottingham, Nottingham NG7 2UH. philip.bath@nottingham.ac.uk

ABSTRACT
OBJECTIVES: To review completed trials assessing effect of hormone replacement therapy on subsequent risk of stroke, assessing stroke by pathological type, severity, and outcome.
DESIGN: Systematic review of randomised controlled trials identified from the Cochrane Library, Embase, and Medline; reviews; and reference lists of relevant papers.
STUDIES REVIEWED: 28 trials, with 39 769 subjects, were identified.
REVIEW MEASURES: Rates for cerebrovascular events analysed with a random effects model. Sensitivity analyses for heterogeneity included phase of prevention (primary or secondary), type of hormone replacement therapy (oestrogen alone or combined with progesterone), type of oestrogen (estradiol or conjugated equine oestrogen), size of trial (< 5000 or > 5000 patients), length of follow up (pound 3 years or > 3 years), sex (women only or men only), and trial quality (high or low).
RESULTS: Hormone replacement therapy was associated with significant increases in total stroke (odds ratio 1.29 (95% confidence interval 1.13 to 1.47), n = 28), non-fatal stroke (1.23 (1.06 to 1.44), n = 21), stroke leading to death or disability (1.56 (1.11 to 2.20), n = 14), ischaemic stroke (1.29 (1.06 to 1.56), n = 16), and a trend to more fatal stroke (1.28 (0.87 to 1.88), n = 22). It was not associated with haemorrhagic stroke (1.07 (0.65 to 1.75), n = 17) or transient ischaemic attack (1.02 (0.78 to 1.34), n = 22). Statistical heterogeneity was not present in any analysis.
CONCLUSIONS: Hormone replacement therapy was associated with an increased risk of stroke, particularly of ischaemic type. Among subjects who had a stroke, those taking hormone replacement therapy seemed to have a worse outcome. Hormone replacement therapy cannot be recommended for the primary or secondary prevention of stroke.

CERVICAL SCREENING

Reading 4

Buechler EJ. Pap tests and HPV infection. Advances in screening and interpretation. Postgrad Med. 2005 Aug;118(2):37-40, 43-6.

URL: http://www.postgradmed.com/issues/2005/08_05/buechler.htm (free full text)
Harvard Vanguard Medical Associates, Boston, MA 02215, USA. ebuechler@gmail.com

ABSTRACT
The natural history of human papillomavirus (HPV) is not yet completely understood. But over the past decade, there has been an explosion in knowledge about the virus and its relationship to precancerous and cancerous changes in the genital tract. Recent research in the management of Pap testing, new technologies for Pap screening, and easy access to HPV tests have changed the treatment recommendations in patients with abnormal cytologic results. In this article, Dr Buechler explores these advances and explains how

---

UTERINE FIBROID

Reading 5

Griffin KW, Ellis MR, Wilder L, DeArmond L. Clinical inquiries. What is the appropriate diagnostic evaluation of fibroids? J Fam Pract. 2005 May;54(5):458, 460, 462.

URL: http://www.jfponline.com/Pages.asp?AID=1928 (free full text)
Family Practice Residency, Springfield, Mo., USA.

SUMMARY
Although transvaginal sonography (TVS) has inconsistent sensitivity (0.21–1.00) and specificity (0.53–1.00), its cost-efficiency and noninvasiveness make it the best initial test for ruling in fibroid disease (strength of recommendation [SOR]:B, based on expert opinion, a systematic review, and prospective studies).

Sonohysterography (SHG) and hysteroscopy have superior sensitivity, specificity, and more discriminating positive and negative likelihood ratios for diagnosing fibroids than does TVS (SOR:B, systematic review). SHG is less painful, less invasive, and more cost-effective than hysteroscopy (SOR:B; single, prospective comparative study and cost comparison).

Magnetic resonance imaging (MRI) had comparable precision to TVS in a single study, but it is too expensive to be a good initial test for fibroids (SOR:C, expert opinion and an uncontrolled prospective study). One study reported a strong correlation between ultrasound and bimanual examination (SOR:C, retrospective case review).

OVARIAN CANCER

Reading 6

U.S. Preventive Services Task Force. Screening for ovarian cancer: recommendation statement. U.S. Preventive Services Task Force. : Am Fam Physician. 2005 Feb 15;71(4):759-62.

URL: http://www.aafp.org/afp/20050215/us.html (free full text)

SUMMARY
The USPSTF recommends against routine screening for ovarian cancer. (**D recommendation).** The USPSTF found fair evidence that screening with serum CA-125 level or transvaginal ultrasound can detect ovarian cancer at an earlier stage than it can be detected in the absence of screening; however, the USPSTF found fair evidence that earlier detection would likely have a small effect, at best, on mortality from ovarian cancer. Because of the low prevalence of ovarian cancer and the invasive nature of diagnostic testing after a positive screening test, there is fair evidence that screening could likely lead to important harms. The USPSTF concluded that the potential harms outweigh the potential benefits.

Reading 7

Moss EL, Hollingworth J, Reynolds TM. The role of CA125 in clinical practice. J Clin Pathol. 2005 Mar;58(3):308-12.

URL: http://jcp.bmjjournals.com.libproxy1.nus.edu.sg/cgi/content/full/58/3/308 (payment required)

Department of Obstetrics and Gynaecology, Queen's Hospital, Belvedere Road, Burton upon Trent, Staffordshire DE13 0RB, UK.

ABSTRACT
BACKGROUND: CA125 is a high molecular weight glycoprotein, which is expressed by a large proportion of epithelial ovarian cancers. The sensitivity and specificity of CA125 are poor and there are no guidelines produced by the Royal College of Pathologists or the Association of Clinical Biochemists to aid clinicians and laboratories in its most appropriate use.
AIM: To identify the patient population having a CA125 measurement and to determine its contribution to individual patient management.
METHODS: A retrospective case note audit looking at patients who had a CA125 measurement performed between April 2000 and April 2002.
RESULTS: The study comprised 799 patients; 751 (94%) were female and 48 (6%) male; 221 (29%) females and 22 (46%) males had an abnormal result. CA125 was mainly used to investigate a wide range of signs and symptoms, and few tests were for follow up or screening of ovarian cancer. In female patients having a CA125 for suspicion of malignancy/ovarian cancer, only 39 (20%) of the abnormal results were caused by ovarian cancer. False positive results were largely caused by another malignancy (48 cases; 26%), benign ovarian disease (26 cases; 14%), and benign gynaecological conditions, particularly leiomyomas (18 cases; 9%). The specificity of CA125 for ovarian cancer increased with concentrations >1000 kU/litre.
CONCLUSIONS: These results confirm the high false positive rate and poor sensitivity and specificity associated with CA125. The substantial inappropriate usage of CA125 has led to results that are useless to the clinician, have cost implications, and add to patient anxiety and clinical uncertainty.

BREAST CONDITIONS

Reading 8

Bilous M, Brennan M, French J, Boyages J. Making sense of breast pathology. Aust Fam Physician. 2005 Jul;34(7):581-6.

URL: http://www.racgp.org.au/afp/downloads/pdf/july2005/200507brennan.pdf (free full text)

NSW Breast Cancer Institute, University of Sydney, and Institute of Clinical Pathology and Medical Research, Westmead Hospital, New South Wales, Australia.

ABSTRACT
An understanding of breast pathology is essential when caring for women with breast disease. Part five of this series discusses the spectrum of common benign and malignant conditions including the distinction between invasive and noninvasive breast cancer. It also aims to increase the general practitioner's confidence in understanding breast pathology reports, arranging appropriate referral for patients, and educating women about their disease.

Reading 9

Brennan M, Houssami N, French J. Management of benign breast conditions. Part 3 – Other breast problems. Aust Fam Physician. 2005 May;34(5):353-5.

URL: http://www.racgp.org.au/afp/downloads/pdf/may2005/20050428brennan.pdf (free fulltext)

NSW Breast Cancer Institute, Westmead Hospital, New South Wales. meaganb@bci.org.au

SUMMARY
Nonlactation inflammatory breast conditions, nipple discharge, and gynaecomastia are less common breast symptoms in the general practice setting than breast lumps or breast pain, but nonetheless cause considerable anxiety in patients and can pose challenges in diagnosis and management. Infective conditions should be followed to complete resolution, and where an infective or inflammatory condition does not resolve, the diagnosis of inflammatory breast cancer should be considered. As with all breast symptoms, the GP's role involves excluding cancer and providing an explanation of the patient's condition and appropriate reassurance.

Reading 10

Brennan M, Wilcken N, French J, Ung O, Boyages J. Management of early breast cancer—the current approach. Aust Fam Physician. 2005 Sep;34(9):755-60

URL: http://www.racgp.org.au/afp/downloads/pdf/september2005/September%20_clinPrac_brennan.pdf (free full text)

NSW Breast Cancer Institute, Westmead Hospital, New South Wales, Australia. meaganb@bci.org.au

ABSTRACT
This seventh article in our series on breast disease focuses on what is new in the management of invasive primary breast cancer. Up-to-date information on the key aspects of breast cancer management is presented, including descriptions of the new technique of sentinel lymph node biopsy and the new hormone treatment, aromatase inhibitors. Current trends in surgery for breast cancer and the adjuvant treatments of chemotherapy and radiotherapy are also discussed.